

CHAPTER

14

MISCELLANEOUS

Preventative/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)

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Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)

Preventive and Rehabilitative Services for Primary Care Enhancement (P/RSPCE) are interventions that address medical risk factors that interfere with a patient's ability to maintain an optimal state of health. P/RSPCE support primary medical care. The services are directed toward the maintenance, improvement or protection of health or toward the diagnosis and treatment of illness or disability. These services are funded by State Plan Medicaid.

Its goals are to:

- Prevent disease, disability, and other health conditions or their progression
- Prolong life
- Promote physical and mental health and efficiency
- Reduce physical or mental disability
- Restore an individual to the best possible functional level
- Promote positive health outcomes

This service is available to Medicaid beneficiaries when medically necessary and must either be (1) required for the development and implementation of a comprehensive plan of care by a physician and other appropriate practitioners, or (2) preventive services identified in the comprehensive P/RSPCE plan that are not otherwise covered under the state plan.

The attached "Principles for Interaction Between Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) and Medicaid Home and Community-Based Waiver Programs" must be followed for waiver participants receiving P/RSPCE.

For more information about P/RSPCE, see the Enhanced Services Provider Manual at www.scdhhs.gov.

Principles for Interaction Between Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) and Medicaid Home and Community-Based Waiver Programs

- The short-term, time-limited, medical nature of P/RSPCE and its linkage to primary care are important in understanding the relationship between these two Medicaid services.
- The P/RSPCE provider must fully understand how the waiver program operates, the waiver and state plan services available, and scope of the Community Long Term Care case manager (CM)/Department of Disabilities and Special Needs service coordinator (SC). This is critical to avoid any unnecessary duplication or overlap services.
- It is important that the P/RSPCE provider and the assigned waiver participant's CM/SC communicate exactly what service(s) will be provided as well as the exact expected outcome of the intervention(s) being provided. This communication is necessary to ensure the participant's waiver plan of care/service is documented appropriately by the CM/SC.
- The P/RSPCE provider will document all telephone or personal contacts with the CM/SC in the client's case record.
- P/RSPCE services provided to waiver participants must be within the 30 units/month limit established by DHHS. These services must be efficient, well managed, and must not duplicate any waiver or state plan services.
- DHHS will monitor the amount of P/RSPCE provided to waiver participants through Medicaid expenditure reports.
- Only nutrition services can be routinely provided to waiver participants under P/RSPCE. Service Coordinators need to be aware of any liquid nutrition provided to avoid duplication of services.
- Any other P/RSPCE provided to home and community-based waiver participants must meet one of the criteria below:
 1. Interventions related to a client's complicated medical condition to improve his/her response to treatment or care. There must be clear documentation that the P/RSPCE provider has communicated with the primary care physician and CM/SC concerning the nature of the service(s) to be provided;
 2. Interventions for clients with complicated medical conditions in need of medication management, compliance with a medication regimen, or assistance in procuring medications. Routine situations should be handled through Medicaid state plan (including Medicaid home health services) or waiver services. P/RSPCE involvement should only be for crisis-type situations that are short-term, time-limited, medical, and carefully coordinated with the CM/SC; or
 3. Interventions for clients with complex medical conditions to assure understanding of how multiple medical treatments relate with the effectiveness of the care plan in order to maximize the level of independence and functioning. This may involve attending a discharge or case coordination meeting

(with the CM/SC) where a deinstitutionalization is imminent. This cannot duplicate the functions of the CM/SC.

- Waiver participant's meeting any of the above criteria may be referred for P/RSPCE by their CM/SC.
- These procedures will be communicated to the responsible P/RSPCE staff, CLTC staff, and DDSN staff.

Effective Date: September 1, 1998

For Your Information:

MR/RD Waiver and Hospice Services

When a MR/RD Waiver participant elects to also receive State Plan Hospice Services, the Hospice provider becomes the “Authorizer” of all services. That means that the Service Coordinator/Early Interventionist must obtain authorization from the Hospice provider before board provided waiver services, such as Residential Habilitation, can be provided. Once it is determined what services the participant will receive, the Hospice authorization number should be obtained (e.g. HSP028). This Authorization number must be communicated to the District Waiver Coordinator along with the participant’s name, social security number, county in which he/she resides, date he/she entered Hospice, Medicaid Number, the Service Coordinator/Early Interventionist’s name and the services that the participant will receive. The District Waiver Coordinator will be responsible for reporting this information to SCDDSN Central Office—SURB for billing purposes.

No MR/RD Waiver services may be authorized for participants who elect to receive Hospice Services funded by State Plan Medicaid without a prior authorization number from the Hospice provider.

The following MR/RD Waiver services in the left column may be routinely authorized by DDSN if appropriate. Those services in the right column may not be authorized for clients also receiving the Hospice benefit:

May be routinely authorized if appropriate	May not be authorized
Residential Habilitation	Nursing Services
Prescribed Drugs	Adult Day Health Care
Adult Dental Services	Adult Day Health Care –Nursing
Adult Vision	Audiology Services
Specialized Medical Equipment, Supplies and Assistive Technology *Note: this service will be limited to those items already identified on the plan of service. These services will not be authorized for newly requested items for waiver clients entering hospice.	Attendant Care
Personal Emergency Response System (PERS)	Respite Care
	Behavior Support Services
	Adult Companion Services
	Psychological Services
	Personal Care I and II
	Environmental Modifications
	Private Vehicle Modifications
	Day Activity
	Career Preparation
	Employment Services
	Community Services
	Support Center
	Adult Day Health Care – Transportation

For Your Information:

Out of State Travel

MR/RD Waiver participants may travel out of state and retain a waiver slot under the following conditions:

- the trip is planned and will not exceed 90 consecutive days;
- the participant continues to receive a waiver service consistent with SCDDSN policy;
- the waiver service received is provided by a South Carolina Medicaid provider;
- South Carolina Medicaid eligibility is maintained.

During travel, waiver services will be limited to the frequency of service currently approved in the participant's plan. Services must be monitored according to SCDDSN policy.

The parameters of this policy are established by SCDHHS for all HCB Waiver participants.

For Your Information:

Income Trust

If a potential participant is deemed “not eligible” for Medicaid due to excessive income, he/she may become eligible after an “Income Trust” is established. The potential participant must meet all other Medicaid eligibility criteria.

Under this option, the potential participant establishes a trust account into which all of his/her income is deposited. Each month, after appropriate deductions for living expenses and other fees, Medicaid bills the trust for any Medicaid services provided.

Specific and detailed information about Income Trusts is available from the South Carolina Department of Health and Human Services (SCDHHS/Eligibility).

Trusts must be set up by an attorney or trust professional and must be set up according to the specific guidelines set by SCDHHS/Eligibility.

PURGING A MR/RD WAIVER FILE

- Clearly denote on the working file that there is a back-up file by placing a **Back-Up File Available** sticker on the front of the file or follow your agency's policy for denoting a Back-Up File Available.
- All material (except waiver information) should be purged by calendar year and put in a file that is set up like the working file and labeled as a back-up file.
- The original Social History and all Social Updates remain in the file.
- All Service Agreements will be maintained in the working file.
- Client Rights and Review of Record Form remains in the working file.
- Voter Registration Information remains in the working file.
- Retain previous and current Plan in the working file.
- Current medical exam and medical records should be in the file.
- All psychological evaluations remain in the working file.
- Current and previous IEP/IPP, if applicable, should be retained in the working file.
- The DDSN Eligibility letter should remain in the working file.
- Contact notes will be purged according to calendar year. The current year should remain along with two previous years to coincide with the budgets.
- The Freedom of Choice, Waiver Enrollment letter, Notice of Slot Allotment (MR/RD Form 5), and all Level of Care determinations remain in the working file.
- Waiver budget information should be purged according to fiscal year (e.g. 7/1/10-6/30/11) along with pertinent documents (e.g. referrals, monthly utilization forms, requisitions/invoices and progress notes) regarding waiver services. The current contract period should remain along with the previous contract period. This should coincide with contact notes (i.e. if the current contract period is 7/1/10-6/30/11, then this information must be retained in the working file along with 7/1/09-6/30/10 budget information and supporting documents which coincide with service notes from 2009-2011 – the service notes would be purged back to 1/1/09).

Children's Personal Care

Children's Personal Care Aide Services (CPCA) are available to Medicaid eligible children under age 21 who meet established medical necessity criteria. To qualify for CPCA services a child must meet the Service Needs Requirement and, unless otherwise specified, have one of the Functional deficits listed below:

Service Needs Requirement

A physician must certify that the child requires daily monitoring and observation due to medical needs which could result in complications and that the services of a Personal Care Aide are required and intended to maintain the child's optimum health status.

Functional Deficits*

1. Requires extensive (hands on) assistance with bathing and dressing and toileting and feeding if otherwise age appropriate** functioning would normally allow these activities. (All four must be present and constitute one deficit).
2. Requires extensive (hands on) assistance with walking or wheelchair locomotion if these are otherwise age appropriate activities**.
3. Requires extensive (hands on) assistance with transfer if otherwise age appropriate activity**.
4. Requires extensive (hands-on) assistance with daily incontinence care (if continence is otherwise age appropriate**) or with daily catheter or ostomy care.

* For infants, ages 0-1, functional deficits generally will not apply. Medical necessity is based on Service Needs Requirement only.

** For children 0-5 years of age, Attachment A-“Guide to Developmental Stages of Children” may be used to determine age-appropriate activity.

Note: To receive CPCA services, a child must meet the Service Needs Requirements and have at least one (1) Functional Deficit.

CPCA Services are designed to help with normal daily activities and to monitor the medical conditions of the child. Aides providing this service may assist with ambulation/walking, bathing, dressing, toileting, grooming, preparing meals and feeding. In addition to the hands-on care provided to the child, aides may also help to maintain the child's home environment by performing light cleaning, laundry for the child and tasks to keep the home safe for the child but these tasks may not be performed as discrete activities.

Aides work under the supervision of an RN or LPN but may not perform any type of skilled medical services. Aides may observe the child's vital signs such as respiratory rate, pulse rate and temperature.

During the provision of the CPCA services, aides must be actively engaged in the completion of allowable tasks determined by the service coordinator to be needed. The provision of this service does not include supervision of the child (“childcare”) as a discrete task, nor does it include down-time between tasks or time waiting for a task to be needed.

A Personal Care Aide is not allowed to render services in a school setting or during homebound instruction. CPCA must be provided in the recipient's home.

The unit of service is 15 minutes of service provided by one PCA.

Please see: Scope of Services for Personal Care 2 (PC II) Services

Providers: Personal Care Services must be provided to children by an agency enrolled with the Department of Health and Human Services.

Arranging for and Authorizing the Service: When a child is believed to have needs that can be met through the provision of CPCA Services, access to those services may be obtained in one of two ways.

1. For children NOT ENROLLED in the Department of Disabilities and Special Needs' (DDSN) Mental Retardation/Related Disabilities (MR/RD) Waiver or Community Supports (CS) Waiver, access to CPCA is gained by referring the child to the Community Long Term Care (CLTC) area office in the child's area. For these children, when determined by a physician to qualify for the service, assessment of need and authorization of the service is made by CLTC area office staff.

2. For children who ARE ENROLLED in either the MR/RD Waiver or CS Waiver, when determined by a physician to qualify for CPCA services, the assessment of need and authorization of services is made by the child's DDSN contracted Service Coordination/Early Intervention provider (i.e., the Service Coordinator/Early Interventionist). The Service Coordinator will obtain a physician's order using the attached MSP Form 1. The Service Coordinator will also complete the CPCA Assessment (attached MSP Form 2).

Service Approval: Beginning 3/1/2011, at the time of annual planning, all children enrolled in the MR/RD or CS Waiver must have a newly completed physician's order, assessment, and authorization (see MSP forms/attachments). For children meeting both the "Service Needs Requirement" and who have a "Functional Deficit," Service Coordinators may authorize up to 10 hours (40 units) per week without additional prior approval. If the assessment indicates a need for services in excess of 10 hours (40 units) per week, prior authorization from DDSN Central Office must be obtained. Requests must:

- specifically explain need/reason for the amount of service
- include the completed assessment
- include the proposed schedule for service delivery
- include supporting medical documentation
- be submitted to: Angela Syphertt (see contact information below) for review and approval.

NOTE: Under no circumstances, shall an amount in excess of 10 hours (40 units) per week be authorized without prior approval from DDSN.

Contact: Angela Syphertt

Mail: SCDDSN, PO Box 4706, Columbia, SC 29240

E-mail: Asyphertt@ddsn.sc.gov Fax: (803) 898-9660

CPCA Services should not be included in the Waiver budget.

NOTE: If the completed physician's order or assessment indicates that either no service is needed or a reduced amount of service is needed, the service coordinator must issue a Notice of Termination/Reduction or Suspension at least ten (10) working days prior to the actual termination/reduction of the service. The reconsideration/appeals process must be attached.

Once the Service Coordinator has assessed the amount of services needed, obtained a Physician's order, and, if applicable, obtained approval from DDSN, the parents/guardian should be given a listing of available Personal Care providers from which to choose. This offering of provider choice must be documented. Once the service is approved and a Personal Care provider is selected, the Service Coordinator should complete the Authorization for Children's Personal Care Aide Services (MSP Form 3) and send a copy to the chosen agency. This authorization remains in effect until a new/revised Authorization for Children's Personal Care Aide Services is sent or until services are terminated. **The physician's order must be attached to the authorization.**

Monitoring Services: Because CPCA is not a waiver service, the Service Coordinator need only monitor CPCA as part of routine "Plan Review."

Reduction, Suspension or Termination of Services: If services are to be reduced, suspended or terminated, a written notice must be sent to the parent/guardian including the details regarding the change(s) in service, the allowance for appeal, and a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed and sent to the parent/guardian) before the reduction, suspension or termination of the waiver service(s) takes effect. The attached MSP Form 4 will be used to reduce, suspend or terminate the service when applicable.

NOTE: When a child turns 21 years old, Children's PCA services can no longer be received as a State Plan Medicaid service. Please refer to the Enrollments Chapter in the appropriate waiver manual for instructions on how to transition a child from Children's PCA Services to waiver-funded Personal Care Services.

Guide to Developmental Stages of Children**1 month**

- Makes crawling movements when prone
- When held in standing position, body limp at knees and hips
- In sitting position back is uniformly rounded, absence of head control

2 months

- Turns from side to back
- When prone, can lift head almost 45 degrees off table
- When held in sitting position, holds head up but head bobs forward

3 months

- Holds head high, makes crawling movements when prone
- Able to hold head more erect when sitting, but still bobs forward
- When held in standing position, able to bear slight fraction of weight on legs
- Supports weight on forearms
- Able to raise head and shoulders from prone position to 45-90 degree angle from table
- Opens hand spontaneously

4 months

- Rolls from back to side
- Able to sit erect if propped up
- Supports weight on feet briefly with underarm support

6 months

- When held in standing position, bears almost all of weight
- Sits with support
- Lifts legs high, holds them out straight

7 months

- Bears full weight on feet
- Rolls over easily
- Sits without support
- Pushes up on hands and knees and rocks

8 months

- Readily bears weight on legs when supported, may stand holding onto furniture
- Crawls on belly – arms used to pull body forward

9 months

- Crawls, may progress backward at first
- Sits steadily on floor for prolonged time (10 minutes)
- Pulls self to standing position and stands holding onto furniture
- Makes stepping movements

10 months

- Pulls self up
- Can hold bottle and feed self crackers
- Can drink from cup
- Crawls by pulling self forward with hands
- Pulls self to sitting position
- Stands while holding onto furniture, sits by falling down

12 months

- Begins to stand alone and toddle

- Uses spoon
- Cruises or walks holding onto furniture or with hand held
- May attempt to stand alone momentarily
- Can sit down from standing position without help

15 months

- Walks without help (usually since age 13 months)
- Creeps up stairs
- Assumes standing position without support
- Uses cup well
- Feeds self with regular cup with little spilling

18 months

- Runs clumsily, falls often
- Walks upstairs with one hand held
- Seats self on chair
- Manages spoon, but some spilling
- Takes off gloves, socks, and shoes and unzips

24 months

- Walks up and down stairs, has steady gait
- Holds cup for drinking
- Feeds self with spoon
- Cooperates with toilet training
- Runs fairly well, with wide stance
- Dresses self in simple clothing
- Participates in bathing

3 years

- Undresses self, washes and dries hands
- Feeds self with spoon
- May attend to toilet needs without help except for wiping
- Buttons and unbuttons accessible buttons
- Pulls on shoes
- Should have achieved daytime bowel and bladder control with occasional accidents

4 years

- Buttons front and side of clothes
- Bathes self with directions

5 years

- Has good motor control
- Washes self
- Cares for self totally, occasionally needing supervision in dress or hygiene
- Should have achieved daytime and nighttime bowel and bladder control

Revised 10/7/09

**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
CHILDREN'S PERSONAL CARE AIDE (PCA)
PHYSICIAN INFORMATION FORM**

CHILD'S NAME: _____

SECTION I – MEDICAL INFORMATION

DATE OF LAST OFFICE VISIT: _____

DIAGNOSIS: _____

CURRENT PHYSICAL CONDITION AND LIMITATIONS: _____

CURRENT MEDICATIONS AND TREATMENT PLAN: _____

SECTION II – THE INFORMATION IN THIS SECTION IS REQUIRED IN ORDER TO DETERMINE IF THE CHILD QUALIFIES FOR THIS SERVICE.

SERVICE NEED: (CIRCLE ONE)

YES NO THE INDIVIDUAL REQUIRES DAILY MONITORING AND OBSERVATION DUE TO MEDICAL NEEDS WHICH COULD RESULT IN MEDICAL COMPLICATIONS. THE MEDICAL NEEDS ARE DOCUMENTED, AND THE SERVICES OF A PERSONAL CARE AIDE ARE REQUIRED AND INTENDED TO MAINTAIN OPTIMUM HEALTH STATUS. **(NOTE: A PERSONAL CARE AIDE CANNOT PERFORM ANY SKILLED TASKS)**

PLEASE SPECIFY:

HOW LONG WOULD YOU EXPECT PCA SERVICES TO BE NEEDED?

☐ 3 MONTHS ☐ 6 MONTHS ☐ 9 MONTHS ☐ 12 MONTHS ☐ INDEFINITE

PLEASE CONTINUE ON REVERSE SIDE OR NEXT PAGE

SECTION III

PLEASE CHECK BELOW ALL SPECIFIC CARE NEEDS NECESSARY FOR THIS CHILD AND INDICATE THE FREQUENCY:

<u>SPECIAL CARE OR TREATMENT</u>		<u>FREQUENCY</u>	<u>DIETARY</u>		<u>FREQUENCY</u>
	MONITOR MEDICATIONS			TUBE FEEDING	
	CATHETER/OSTOMY			SPECIAL DIET	
	VITAL SIGNS			TYPE:	
	SAFETY		COMMENTS:		
	VENTILATOR				
	TRACHEOSTOMY				
	SUCTIONING				
	OTHER (SPECIFY)				

PHYSICIAN SIGNATURE

DATE

PHYSICIAN NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
CHILDREN'S PERSONAL CARE AIDE ASSESSMENT

WAIVER PARTICIPANT'S NAME: _____ DOB/AGE: _____ / _____

I. PLEASE LIST ALL MEDICAL CONDITIONS AND WHEN EACH CONDITION FIRST OCCURRED. USE AN EXTRA SHEET OF PAPER IF YOU NEED MORE SPACE.

DIAGNOSIS/MEDICAL CONDITION	DATE FIRST OCCURRED
1.	
2.	
3.	
4.	

II. LIST ALL PERSONS INCLUDING PAID SERVICE PROVIDERS (E.G., NURSES, RESPITE CARE, ETC) WHO ARE NOW HELPING CARE FOR THE CHILD. USE AN EXTRA SHEET OF PAPER IF MORE SPACE IS NEEDED.

PERSON/RELATIONSHIP	TIMES EACH DAY & DAYS EACH WEEK WHEN HELPING

III. PROVIDE A TWO WEEK SCHEDULE THAT SHOWS HOW/WHEN SERVICES/SUPPORTS (INCLUDING NATURAL SUPPORTS) ARE PROVIDED. INCLUDE THE ANTICIPATED SCHEDULE FOR PERSONAL CARE. USE AN EXTRA SHEET OF PAPER IF MORE SPACE IS NEEDED.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

ASSISTANCE NEEDED**ASSISTANCE REQUIRED****FREQUENCY, TIME REQUIRED,**
TIMES PER WEEK**A. PERSONAL CARE**BATH: BED ☐ SHOWER/TUB ☐EXTENSIVE ☐ PARTIAL ☐ NONE ☐; ___ X DAILY, 30 MIN ☐ OTHER ___, ___ X WEEKLY

ORAL HYGIENE:

EXTENSIVE ☐ PARTIAL ☐ NONE ☐; ___ X DAILY, 10 MIN ☐ OTHER ___, ___ X WEEKLY

SKIN CARE:

EXTENSIVE ☐ PARTIAL ☐ NONE ☐; ___ X DAILY, 10 MIN ☐ OTHER ___, ___ X WEEKLYDRESSING AND GROOMING:EXTENSIVE ☐ PARTIAL ☐ NONE ☐; ___ X DAILY, 15 MIN ☐ OTHER ___, ___ X WEEKLYSHAVING (AGE APPROPRIATE -14 OR OVER): ☐ N/AEXTENSIVE ☐ PARTIAL ☐ NONE ☐; ___ X DAILY, 15 MIN ☐ OTHER ___, ___ X WEEKLYINCONTINENCE CARE: (FOR CHILDREN AGE 4 & UP):EXTENSIVE ☐ PARTIAL ☐ NONE ☐; ___ X DAILY, 30 MIN ☐ OTHER ___, ___ X WEEKLYTOILETING:EXTENSIVE ☐ PARTIAL ☐ NONE ☐; ___ X DAILY, 15 MIN ☐ OTHER ___, ___ X WEEKLY

RE-POSITIONING/TURNING IN BED:

EXTENSIVE ☐ PARTIAL ☐ NONE ☐; ___ X DAILY, 10 MIN ☐ OTHER ___, ___ X WEEKLY

MONITORING MEDICATION:

EXTENSIVE ☐ PARTIAL ☐ NONE ☐; ___ X DAILY, 10 MIN ☐ OTHER ___, ___ X WEEKLY(E.G., INFORMING THAT IT IS TIME TO TAKE MEDICATION AS PRESCRIBED OR AS INDICATED ON THE LABEL OR HANDING A MEDICATION CONTAINER – THE AIDE IS NOT RESPONSIBLE FOR GIVING MEDICATIONS).

MEDICAL MONITORING OF CONDITION – SPECIFY:

(E.G., MONITOR TEMPERATURE, CHECK PULSE RATE, OBSERVE RESPIRATORY RATE OR CHECK BLOOD PRESSURE).

EXTENSIVE ☐ PARTIAL ☐ NONE ☐ FREQUENCY, TIME REQUIRED ___, ___ X WEEKLYEXTENSIVE ☐ PARTIAL ☐ NONE ☐ FREQUENCY, TIME REQUIRED ___, ___ X WEEKLY

EXERCISE:

EXTENSIVE ☐ PARTIAL ☐ NONE ☐ FREQUENCY, TIME REQUIRED ___, ___ X WEEKLYTRANSFERS:MANUAL ☐EXTENSIVE ☐ PARTIAL ☐ NONE ☐ ___ X DAILY, 10 MIN ☐ OTHER ___, ___ X WEEKLYHOYER ☐EXTENSIVE ☐ PARTIAL ☐ NONE ☐ ___ X DAILY, 10 MIN ☐ OTHER ___, ___ X WEEKLYSLIDING BOARD ☐EXTENSIVE ☐ PARTIAL ☐ NONE ☐ ___ X DAILY, 10 MIN ☐ OTHER ___, ___ X WEEKLYLIFT SYSTEM ☐EXTENSIVE ☐ PARTIAL ☐ NONE ☐ ___ X DAILY, 10 MIN ☐ OTHER ___, ___ X WEEKLYWALKING: ☐ N/A – CAN'T WALKEXTENSIVE ☐ PARTIAL ☐ NONE ☐ ___ X DAILY, 10 MIN ☐ OTHER ___, ___ X WEEKLYWHEELCHAIR LOCOMOTIONEXTENSIVE ☐ PARTIAL ☐ NONE ☐ ___ X DAILY, 10 MIN ☐ OTHER ___, ___ X WEEKLY

OTHER: _____

EXTENSIVE ☐ PARTIAL ☐ NONE ☐ ___ X DAILY, 30 MIN ☐ OTHER ___, ___ X WEEKLY

OTHER PERSONAL CARE NEEDS:

EXTENSIVE ☐ PARTIAL ☐ NONE ☐ ___ X DAILY, 30 MIN ☐ OTHER ___, ___ X WEEKLYEXTENSIVE ☐ PARTIAL ☐ NONE ☐ ___ X DAILY, 30 MIN ☐ OTHER ___, ___ X WEEKLY**ASSISTANCE/TIME NEEDED FOR PERSONAL CARE (TOTAL SECTION A):** _____**B. MEAL AND DINING**

PREPARATION AND SET-UP:

EXTENSIVE ☐ PARTIAL ☐ NONE ☐ ___ X DAILY, 30 MIN ☐ OTHER ___, ___ X WEEKLYDINING/FEEDING:EXTENSIVE ☐ PARTIAL ☐ NONE ☐ ___ X DAILY, 30 MIN ☐ OTHER ___, ___ X WEEKLY

CLEAN UP:

EXTENSIVE ☐ PARTIAL ☐ NONE ☐ ___ X DAILY, 30 MIN ☐ OTHER ___, ___ X WEEKLY**ASSISTANCE/TIME NEEDED FOR MEALS/DINING (TOTAL SECTION B):** _____

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GENERAL/HOUSEHOLDFLOOR CLEANING PARTICIPANT'S ROOM/AREA: ____ X WEEKLY, 15 MIN ☐ OTHER ____DUSTING PARTICIPANT'S ROOM/AREA: ____ X WEEKLY, 15 MIN ☐ OTHER ____STRAIGHTENING PARTICIPANT'S ROOM/AREA: ____ X WEEKLY, 30 MIN ☐ OTHER ____CHANGING BED LINENS: ____ X WEEKLY, 15 MIN ☐ OTHER ____PARTICIPANT'S LAUNDRY: ____ X WEEKLY, 90 MIN ☐ OTHER ____**ASSISTANCE/TIME NEEDED GENERAL/HOUSEHOLD (TOTAL SECTION C):** _____**TOTAL ASSISTANCE/TIME NEEDED IN ALL AREAS:** _____**NOTES:**_____
SIGNATURE OF PERSON COMPLETING/TITLE_____
DATE

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S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
Medicaid State Plan Services for Children in a HCB Waiver

AUTHORIZATION FOR CHILDREN'S PERSONAL CARE SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: _____

You are hereby authorized to provide

☐ **Personal Care 2 (T1019)** for:

Participant's Name: _____

Date of Birth: _____ **(must not be 21 or older)**

Address: _____

Phone Number: _____

Medicaid #: _____

Social Security #: _____

Only the number of units rendered maybe billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Start Date: _____

Authorized Total – Children's PCA ____ **Units per week (1 unit = 15 minutes)**

Service Tasks Requested:

- ☐ Assistance with personal care activities such as bathing, dressing, toileting, brushing teeth, grooming, shampooing hair, caring for skin, etc.
- ☐ Assistance with meals such as feeding, preparing/cooking meals, post-meal cleanup, etc.
- ☐ Assistance with home care/light housekeeping tasks such as sweeping, light laundry, bed making, changing bed linens, etc.
- ☐ Monitoring conditions such as temperature, checking pulse rate, observation of respiratory rate, checking blood pressure, monitoring medications, etc.
- ☐ Assistance with exercise, locomotion, positioning, etc.

Please note: Physician's order is attached.

Service Coordination Provider: _____ **Service Coordinator Name:** _____

Address: _____

Phone #: _____

 Signature of Person Authorizing Services

 Date

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
NOTICE OF TERMINATION, REDUCTION, DENIAL OR SUSPENSION OF MEDICAID STATE PLAN SERVICE

To: _____
 LEGAL GUARDIAN/PARENT OF WAIVER PARTICIPANT

AND

 SERVICE PROVIDER AGENCY/COMPANY

Re: _____
 CHILD'S NAME DATE OF BIRTH

 MEDICAID ID NUMBER

EFFECTIVE _____, THE FOLLOWING **MEDICAID STATE PLAN** SERVICE:

DATE

- ☐ **CHILDREN'S PERSONAL CARE**
☐ **CHILDREN'S STATE PLAN NURSING**

IS BEING: ☐ **TERMINATED:** _____
☐ **REDUCED:** A NEW AUTHORIZATION WITH ADJUSTED UNITS WILL BE ISSUED
☐ **SUSPENDED:** AUTHORIZATION WILL BE ISSUED WHEN SERVICES CAN BEGIN
☐ **DENIED:** _____

ONLY UNITS OF SERVICE RENDERED PRIOR TO OR ON THE EFFECTIVE DATE NOTED ABOVE MAY BE BILLED.

 SIGNATURE OF SERVICE COORDINATOR

 PRINT NAME

 DATE OF ISSUE/SIGNED:

SC CONTACT INFORMATION:

 AGENCY

 PHONE NUMBER

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS for MEDICAID STATE PLAN SERVICES

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for authorizing certain Medicaid State Plan services for the Mental Retardation/Related Disabilities (MR/RD) Waiver, Community Supports Waiver (CS) and Head and Spinal Cord Injury (HASCI) Waiver participants. A request for reconsideration of an adverse decision **must be** sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process **must be** completed in its entirety before appealing to the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the participant, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for benefits/services to continue during the reconsideration/appeal process, the participant/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the participant/representative may be required to repay the costs of benefits/services received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the participant/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the participant/representative fully completes the above reconsideration process and is dissatisfied with the results, the participant/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The participant/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision:

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The participant/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the participant/representative must clearly state with specificity, which issue(s) the participant/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30th) calendar day following receipt of the SCDDSN written reconsideration decision. The participant/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.